

# A New Dimension in Supplemental Cancer Insurance

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*Underwritten by:*

*Loyal American*  
Life Insurance Company®

Administrative Office: P.O. Box 1604

Duncan, OK 73534

**Toll Free: 1-800-366-8354**

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## **A Promise**

In an era where many financial services companies are concerned with bottom-line results at the expense of customer service and loyalty, we come from the old school. We take great pride in providing the finest services to our employer groups, policyholders, business associates, agents - to everyone with whom we come in contact.

*The following is not an exhaustive list of terms and conditions but only serves as a depiction of benefits and exclusions. Interested parties should consult and contract for a complete listing of terms and conditions.*

# BASE POLICY BENEFITS

## No Lifetime Maximum for Majority of Benefits

**BENEFIT PROVISIONS.** We will pay the benefits described in the policy for the treatment of an Insured Person's Cancer, provided he or she is covered under an issued policy which remains in force. Payment will be made in accordance with all applicable policy provisions. Benefits are payable for a positive diagnosis that begins more than 30 days after the Effective Date. For policies issued on a payroll deduction basis, benefits are payable for a positive diagnosis that begins after the Effective Date. The positive diagnosis must be for Cancer as defined in the policy.

- 1. POSITIVE DIAGNOSIS BENEFIT.** We will pay the actual charge but not to exceed **\$300 per Calendar Year** for one test that confirms the Positive Diagnosis of Cancer in an Insured Person. This benefit is not payable for multiple diagnoses of the same Cancer or for Cancer that metastasizes or for recurrence of the same Cancer.
- 2. NATIONAL CANCER INSTITUTE DESIGNATED COMPREHENSIVE CANCER TREATMENT CENTER EVALUATION/CONSULTATION BENEFIT** We will pay the actual charge, but not to exceed a **lifetime maximum of \$750**, if an Insured Person is diagnosed with Internal Cancer and seeks evaluation or consultation from a National Cancer Institute designated Comprehensive Cancer Treatment Center. If the Comprehensive Cancer Treatment Center is located more than 30 miles from the Insured Person's place of residence, We will also pay the transportation and lodging expenses incurred but not to exceed a **lifetime maximum of \$350**. This benefit is not payable on the same day a Second or Third Surgical Opinion Benefit is payable and is in lieu of the Non-Local Transportation and Lodging Expense Benefits of the Policy. **This benefit is payable one time during the lifetime of the Insured Person.**
- 3. SECOND AND THIRD SURGICAL OPINION EXPENSE BENEFIT** We will pay the **actual charge** for a written second surgical opinion concerning the recommendation of Cancer surgery and if the second surgical opinion is in conflict with that of the Physician originally recommending the surgery and the Insured Person desires a third opinion, We will pay the actual charge for a written third surgical opinion. The Physician providing the second or third surgical opinion cannot be associated with the Physician who originally recommended the surgery. This benefit is not payable the same day the National Cancer Institute Evaluation/Consulting Benefit is payable.
- 4. MEDICAL IMAGING, TREATMENT PLANNING AND MONITORING EXPENSE BENEFIT** We will pay the actual charge, but not to exceed **\$1,000 per Calendar Year**, for laboratory tests, diagnostic X-rays, medical images, when used in Cancer treatment plannings related to Radiation Treatment, Chemotherapy or Immunotherapy.
- 5. ANTI-NAUSEA MEDICATION EXPENSE BENEFIT** We will pay the actual charge for anti-nausea medication, but not to exceed **\$150 per Calendar Month**, when an Insured Person is prescribed such medication as the result of Radiation Treatment, Chemotherapy or Immunotherapy treatments for Cancer.
- 6. COLONY STIMULATING FACTOR OR IMMUNOGLOBULIN EXPENSE BENEFIT** We will pay the actual charge but not to exceed **\$1,000 per Calendar Month** for Colony Stimulating Factor Drugs or Immunoglobulins prescribed by a Physician or Oncologist during an Insured Person's Cancer treatment regimen for which benefits are payable under the Radiation, Chemotherapy and Immunotherapy Benefit of this Policy or rider attached to it.
- 7. OUTPATIENT HOSPITAL OR AMBULATORY SURGICAL CENTER EXPENSE BENEFIT** We will pay the **actual charge** from an Ambulatory Surgical Center or Outpatient department of a Hospital for the use of its facilities for the performance of a surgical procedure covered under this Policy but not to exceed **\$350 per day**.
- 8. PROSTHESIS EXPENSE BENEFIT**
  - (A.) Surgically Implanted Breast Prosthesis** We will pay the **actual charge** for a surgically implanted prosthetic device required and prescribed to restore normal body contour lost as the direct result of an Insured Person's breast removal for the treatment of Cancer. The Surgically Implanted Breast Prosthesis Benefit does not include coverage for breast reconstruction surgery which may be covered under the Surgical Schedule within the Surgical and Anesthesia Benefits Rider.
  - (B.) Non-Surgically Implanted Prosthesis** We will pay the actual charge **not to exceed \$2,000 per amputation** for an artificial limb or other non-surgically implanted prosthetic device that is prescribed and required to restore normal body function lost as the direct result of an Insured Person's amputation for the treatment of Cancer. **We will pay a lifetime maximum of \$2,000 per amputation.** The cost of replacement of a prosthetic device is not covered. Hairpieces or wigs are not covered under this benefit.
- 9. NON-LOCAL TRANSPORTATION EXPENSE BENEFIT** We will pay the **actual charge, but not to exceed the coach fare on a Common Carrier for the Insured Person and one adult companion's travel** to a Hospital, Radiation Therapy Treatment Center, Chemotherapy Treatment Center, Oncology Clinic or any other specialized treatment center where the Insured Person receives treatment for Cancer. This benefit is payable only if the treatment is not available Locally but is available Non-Locally. The adult companion may include the live donor of bone marrow or stem cells used in a bone marrow or stem cell transplant for the Insured Person. At the option of the Insured Person, We will pay a single private **vehicle mileage allowance of \$.50 per mile** for Non-Local transportation in lieu of the common carrier coach fare.

- 10. LODGING EXPENSE BENEFIT** We will pay the actual charge **not to exceed \$75 per day** for a room in a motel, hotel or other appropriate lodging facility (other than a private residence), when an Insured Person receives treatment for Cancer at a Non-Local Hospital, Radiation Therapy Treatment Center, Chemotherapy Treatment Center, Oncology Clinic or any other specialized treatment center. The room must be occupied by the Insured Person or an adult companion which may include the live donor of bone marrow or stem cells used in a bone marrow or stem cell transplant for the Insured Person. This benefit is not payable for lodging expense incurred more than 24 hours before the treatment nor for lodging expense incurred more than 24 hours following treatment. **This benefit is limited to 100 days per Calendar Year.**
- 11. INPATIENT BLOOD, PLASMA AND PLATELETS EXPENSE BENEFIT** We will pay the actual charge **not to exceed \$300 per day** for the procurement cost, administration, processing and cross matching of blood, plasma or platelets administered to an Insured Person in the treatment of Cancer while an Inpatient.
- 12. OUTPATIENT BLOOD, PLASMA AND PLATELETS EXPENSE BENEFIT** We will pay **the actual charge not to exceed \$300 per day** for the procurement cost, administration, processing and cross matching of blood, plasma or platelets administered to an Insured Person in the treatment of Cancer while an Outpatient.
- 13. BONE MARROW DONOR EXPENSE BENEFIT** We will pay the Daily Hospital Confinement Benefit shown on the Policy Schedule for each day a live donor, other than the Insured Person, is confined in a Hospital for the harvesting of bone marrow or stem cells used in a bone marrow or stem cell transplant for the treatment of an Insured Person's Cancer.
- 14. BONE MARROW OR STEM CELL TRANSPLANT EXPENSE BENEFIT** We will pay the actual charge not to exceed a **lifetime maximum of \$15,000 for surgical and anesthesia procedures** (including the harvesting and subsequent re-infusion of blood cells or peripheral stem cells ) performed for a bone marrow transplant and/or a peripheral stem cell transplant for the treatment of an Insured Person's Cancer. This benefit will be paid in lieu of the Surgical Expense Benefit and the Anesthesia Expense Benefit which may be described in a rider attached to an issued policy.
- 15. AMBULANCE EXPENSE BENEFIT** We will pay the **actual charge** for ambulance service if an Insured Person is transported to a Hospital where he or she is admitted as an inpatient for the treatment of Cancer . The ambulance service must be provided by a licensed professional ambulance company or an ambulance owned by the Hospital.
- 16. INPATIENT OXYGEN EXPENSE BENEFIT** We will pay the actual charge **not to exceed \$300 per Hospital confinement** for oxygen prescribed by a Physician and received by an Insured Person while confined in a Hospital for the treatment of Cancer.
- 17. ATTENDING PHYSICIAN EXPENSE BENEFIT** We will pay the actual charge **not to exceed \$40 per day** for the professional services of a Physician or Oncologist rendered to an Insured Person while he or she is confined in a Hospital for the treatment of Cancer. This benefit is payable only if the Physician or Oncologist personally visits the Hospital room occupied by the Insured Person and the amount stated is the maximum amount that will be payable for each day of Hospital confinement regardless of the number of visits made by one or more Physicians or Oncologists.
- 18. INPATIENT PRIVATE DUTY NURSING EXPENSE BENEFIT** We will pay the actual charge **not to exceed \$150 per day** for the full time service of a Nurse that is required and ordered by a Physician when an Insured Person is confined in a Hospital for the treatment of Cancer. The Nurse must provide services other than those normally provided by the Hospital and the Nurse may not be an employee of the Hospital or an Immediate Family Member of the Insured Person.
- 19. OUTPATIENT PRIVATE DUTY NURSING EXPENSE BENEFIT** We will pay the actual charge **not to exceed \$150 per day** limited to the same number of days of the prior Hospital confinement for the full time service of a Nurse that is required and ordered by a Physician when an Insured Person is confined indoors at home as the result of Cancer . This benefit is not payable if the services of the Nurse are custodial in nature or to assist the Insured Person in the activities of daily living. This benefit is not payable when the Nurse is a member of the Insured Person's Immediate Family. Charges must begin following a period of Hospital confinement for which benefits are payable under this Policy.
- 20. CONVALESCENT CARE FACILITY EXPENSE BENEFIT** We will pay the actual charge **not to exceed \$100 per day** for an Insured Person's confinement in a Convalescent Care Facility. The maximum number of days for which this benefit is payable will be the number of days in the last Period of Hospital Confinement that immediately preceded admission to a Convalescent Care Facility. The Convalescent Care Facility Confinement must: be due to Cancer ; begin within 14 days after the Insured Person has been discharged from a Hospital for the treatment of Cancer ; be authorized by a Physician as being medically necessary for the treatment of Cancer.
- 21. RENTAL OR PURCHASE OF MEDICAL EQUIPMENT EXPENSE BENEFIT** We will pay the **lesser of the actual charge** not to exceed **\$1,500 per Calendar Year** for either the rental or purchase of covered medical equipment designed for home use, required and ordered by the Insured Person's attending Physician as the direct result of the treatment of Cancer. Covered medical equipment includes wheel chair, oxygen equipment, respirator, braces, crutches or hospital bed.

**22. HOME HEALTH CARE EXPENSE BENEFIT** We will pay benefits for the following Covered Charges when a Insured Person requires Home Health Care for the treatment of Cancer.

1. **Home Health Care Visits** - We will pay the actual charge for Home Health Care Visits **not to exceed \$75 for each day** on which one or more such visits occur. We will not pay this benefit for more than **60 days** in any Calendar Year.
2. **Medicine and Supplies** - We will pay the actual charged **not to exceed \$450 in any Calendar Year** for drugs, medicine, and medical supplies provided by or on behalf of a Home Health Care Agency.
3. **Services of a Nutritionist** - We will pay the actual charge **not to exceed a lifetime maximum of \$300** for the services of a nutritionist to set up programs for special dietary needs.

**23. HOSPICE CARE EXPENSE BENEFIT** We will pay the actual charge for Hospice Care **not to exceed \$100 per day**, when such care is required because of Cancer. This benefit is payable whether confinement is required in a Hospice Center or services are provided in the Insured Person's home by a Hospice Team. Eligibility for payments will be based on the following conditions being met: (1) the Insured Person has been given a prognosis as being Terminally Ill with an estimated life expectancy of 6 months or less; and (2) We have received a written summary of such prognosis from the attending Physician. We will not pay this benefit while the Insured Person is confined to a Hospital or Convalescent Care Facility. **The lifetime maximum benefit is 365 days of Hospice Care**

**24. HAIRPIECE EXPENSE BENEFIT** We will pay the actual charge not to exceed **a lifetime maximum of \$150** for the purchase of a wig or hairpiece that is required as the direct result of hair loss due to Cancer treatment.

**25. PHYSICAL, SPEECH, AUDIO THERAPY AND PSYCHOTHERAPY EXPENSE BENEFIT**

We will pay the actual charge **not to exceed \$25 per therapy session** for:

1. Physical therapy treatments given by a license Physical Therapist, or
2. Speech therapy given by a licensed Speech Pathologist/Therapist; or
3. Audio therapy given by a licensed Audiologist; or
4. Psychotherapy given by a licensed Psychologist.

These sessions may be given at an institute of physical medicine and rehabilitation, a Hospital, or the Insured Person's home. These treatments must be given on an Outpatient basis unless the primary purpose of a Hospital confinement is for treatment of Cancer other than with physical, speech or audio therapy or psychotherapy. **Benefits may not exceed \$1,000 per Calendar Year.**

**26. WAIVER OF PREMIUM.** We will waive the premiums starting on the first premium due date **following a 60 day period of Total Disability** of the Named Insured due to Cancer. The Named Insured must: (a) be receiving treatment for such Cancer for which benefits are payable under this Policy; and (b) remain disabled for 60 consecutive days. We will waive premiums for as long as the Named Insured remains Totally Disabled.

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**GUARANTEED RENEWABLE FOR LIFE.** Except for fraud or material misrepresentation, the Named Insured has the right to renew this Policy as long as premiums are paid on time.

**PREMIUMS SUBJECT TO CHANGE.** On any premium due date after the first Policy Anniversary, We may change the premium rates for this policy only if We also change the rates for all other policies issued in the same Rating Class. No change in the premiums will be made because of the number of claims an Insured Person files nor because of a change in an Insured Person's health.

**EXCLUSIONS AND LIMITATIONS.** No benefits will be paid under the Policy or any attached riders for: 1. any loss due to any disease or illness other than Cancer, or a listed covered Specified Disease; 2. care and treatment received outside the territorial limits of the United States; 3. treatment by any program engaged in research that does not meet the criteria for Experimental Treatment as defined; 4. treatment that has not been approved by a Physician as being medically necessary; or 5. losses or medical expenses incurred prior to the Effective Date of an Insured Person's coverage regardless of the Date of Positive Diagnosis.

**PRE-EXISTING CONDITIONS LIMITATION.** We will not pay benefits for expenses resulting from Pre-existing Conditions during the first two years (in SD for the first 12 months, in TX for the first 6 months if the age at issue is over 64 years) after coverage becomes effective.

**"Pre-existing Condition"** means Cancer, or a listed Specified Disease if that optional rider is issued, which was diagnosed by a Physician or for which medical consultation, advice or treatment was recommended by or received from or sought from a Physician within five years (in SD within one year, in WV within two years) prior to the effective date of coverage for each Insured Person.

**In MS "Pre-existing Condition"** means Cancer, or a listed Specified Disease if that optional rider is issued, for which diagnosis, advice or treatment is given or for which signs or symptoms cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the 12 months immediately preceding the effective date of coverage.

**THIS IS A CANCER ONLY POLICY,** which should be used to supplement your existing health care protection.

Insurance coverage is provided by form number series L-6040 and associated riders. This advertisement highlights some features of the policy and riders, but is not the insurance contract. An issued policy and riders set forth, in detail, the rights and obligations of both the insured and the insurance company. Please read the policy and riders for detailed coverage information.